**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345133

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING ___________________________

B. WING _____________________________

**(X3) DATE SURVEY COMPLETED**

C 02/11/2014

**NAME OF PROVIDER OR SUPPLIER**

AVANTE AT WILKESBORO

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1000 COLLEGE ST

WILKESBORO, NC 28697

**FORM APPROVED**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

**OMB NO. 0938-0391**

**PRINTED:** 02/24/2014

**FORM CMS-2567(02-99) Previous Versions Obsolete 2ZIK11**

**If continuation sheet Page 1 of 1**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>INITIAL COMMENTS F 000 No deficiencies cited as result of survey event ID# 2ZIK11.</td>
<td>F 000</td>
<td></td>
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</tr>
</tbody>
</table>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.